Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	DD0224	A. BUILDING: _____ B. WING _____	C 07/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFELINE, INC	525 MAIN STREET SUITE 105 LAUREL, MD 20707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments SITE: DL SERVICE: GH INDIVIDUAL # 8293 On July 2, 2014 an on-site Mortality investigation, MD00086159/PCIS2 #22717, was conducted in response to the death of Individual #8293. Survey activities included review of the individual's agency records, 911 recording, police, EMS and autopsy reports; review of staff records; and interviews with the agency's staff and the staff of Office of the Chief Medical Examiner. Based on the evidence discovered during this investigation, the licensee was found to be noncompliant with COMAR Title 14, Subtitle 31, Office for Children Regulations.	Y 000		
Y2225	14.31.06.05D6 Personnel Admin: Enuf Staff All Positions .05 Personnel Administration. D. The licensee shall: (6) Have sufficient staff to carry out the licensee's administrative, business, clerical, dietary, housekeeping, maintenance, secretarial, and supervisory functions; and This Regulation is not met as evidenced by: Based on review of a hospital record contained in Individual #8293's agency record, the licensee failed to ensure that all essential medical information was available to the medical team during a hospitalization. Findings include:	Y2225		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Y2225	Continued From page 1 Review of a hospital discharge summary from the winter of 2014, contained in Individual #8293's agency record, revealed that members of the hospital ' s medical team made multiple attempts to communicate with the licensee during Individual #8293's seven-day hospitalization. Medical information essential for ensuring continuity of care, including an updated list of medical problems, current medications, ventilator settings, and plan of care, did not accompany the individual to the hospital. The hospital discharge summary indicates that the licensee did not communicate with the hospital regarding the individual until the sixth day of Individual #8293's hospitalization. The individual was discharged on day seven.	Y2225		
Y2340	14.31.06.05F2a Personnel Admin: Trng: Job Shadow Til Able .05 Personnel Administration. F. Training of Child Care Workers. (2) The program administrator shall designate an employee to accompany new direct care employees on initial tours of duty until the employee's supervisor determines that the new employee: (a) Is able to effectively safeguard the health and safety of the children; and This Regulation is not met as evidenced by: Based on review of Individual #8293's agency	Y2340		

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Y2340	Continued From page 2	Y2340		

record and 911 recording, the licensee failed to ensure that staff communicated all relevant information regarding the individual's medical status during a medical emergency.

Findings include:

Documentation in Nursing Notes form in the summer of 2014 revealed the following:

11:00 pm - "It was reported resident stomach is distended and hard supervisor notified and requested for suppository to be given which the nurse on duty gave it." Vital Signs (VS): Temp 96, Pulse 84, BP 105/88 and Spo2 (oxygen saturation level) 98%.

4:15 am - "Resident pulse (radial pulse) was very faint, and 911 was called. Meanwhile another nurse was called to come over to assist with the situation. CPR was started until 911 arrival and took over with the CPR."

Review of the EMS report and the 911 recording revealed that the 911 operator received the call at 4:39 am. Staff provided the number to the house next door rather than the correct house number to the 911 operator.

Review of 911 recording revealed that when asked by the 911 operator what the medical emergency was, LPN #1 stated "Last evening his abdomen was hard and distended." "He doesn't look good." When asked if he was conscious, staff replied, "he's asleep." LPN #1 failed to inform the 911 operator that CPR had already been initiated.

This surveyor attempted to interview LPN #1 without success.

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Y4060	Continued From page 3	Y4060		
Y4060	14.31.06.13A2 Hlth Care: Gen Hlth: Writ Auth 4 Services .13 Health Care. A. General Health Services. The licensee shall: (2) Obtain written authorization from a parent or other authorized individual for emergency and non-emergency medical, dental, or mental health care. This Regulation is not met as evidenced by: Based on review of Individual #8293's agency record, the licensee failed to provide written authorization for emergency medical care when the individual was admitted to a hospital. Findings include: Review of Individual #8293's record revealed a discharge summary from a seven-day hospitalization in the winter of 2014 indicated that legal documents related to consent for medical decision making and care were not available from the licensee until seven days after admission.	Y4060		
Y5895	14.31.07.08K1 Spec Lic Std: DD: Policy: Fund Rights .08 Programs for Children With Developmental Disabilities. K. Policies and Procedures. A licensee shall develop and adopt written policies and procedures in addition to those policies and	Y5895		

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Y5895	Continued From page 4 procedures required in COMAR 14.31.06 to ensure: (1) The fundamental rights of residents in accordance with Health-General Article, §7-1002, Annotated Code of Maryland; This Regulation is not met as evidenced by: Based on review of Individual #8293's agency records and interview with the agency's staff, the licensee failed to ensure clear and consistent medical orders for an individual. Findings include: Review of agency records and interview with the agency's staff revealed that Individual #8293's agency record contained conflicting medical orders on the same page, written on the same date. The orders included both " attempt cardiopulmonary resuscitation (CPR) " and " no CPR, Option A-1. " No CPR, option A-1 means do not attempt CPR and to allow death to occur naturally. The licensee failed to ensure that the staff clarified these conflicting orders. If faced with contradictory orders about an individual's code status, in the event of a cardiac or pulmonary arrest the standard is to begin CPR. In this instance, the staff did initiate CPR and called 911. Despite the attempted CPR, Individual #8293 died. The death certificate indicates that Individual #8293 died of complications of cerebral palsy due to a remote head trauma.	Y5895		